MEDI-CAL UPDATE
Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Chronic Dialysis Clinics

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Contents

Providers Receiving RAD Messages for Over-One-Year Claims

Effective May 1, 2006, providers will no longer receive acknowledgement, approval or denial letters for claims submitted more than 12 months from the month of service and that meet established late submission requirements. Such claims will be noted on a *Remittance Advice Details* (RAD) with a message indicating the status of the claim.

The policy described above applies only to original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining recipient eligibility, reversal of decisions on appealed *Treatment Authorization Requests* (TARs), Medicare/Other Health Coverage delays or other circumstances beyond the provider's control, and were subsequently sent to EDS' Over-One-Year Unit.

This updated information is reflected on manual replacement page ub sub 3 (Part 2).

CCS Service Code Groupings Update

Effective for dates of service on or after July 1, 2006, numerous codes have been end-dated within the California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02 and 07. These end-dated codes appear in bold with a strike through the entire code.

In addition, retroactive to dates of service on or after July 1, 2004, codes have been added to SCGs 01, 02 and 05. These codes are bold and underlined.

It is important to note that on these manual pages SCG 02 includes all codes in SCG 01; SCG 03 includes all codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01, 02 and 03. These same "rules" apply to end-dated codes.

This information is reflected on manual replacement pages cal child ser 1, 5, 6, 11 thru 18 and 21 (Part 2).

New Blood Factor Billing Method for Pharmacy Providers Coming Soon

Effective for dates of service on or after July 1, 2006, pharmacy providers must bill Blood Factor and Anti-Hemophilia Factor products using National Drug Codes instead of billing "By Report." Providers can submit claims hard copy or electronically. However, providers who bill for California Children's Services (CCS) program-only, CCS/Healthy Families, Genetically Handicapped Persons Program (GHPP)-only eligible recipients, or for Medi-Cal/CCS/GHPP-eligible recipients with a CCS or GHPP Legacy or a CCS Service Authorization Request, must continue to bill hard copy with the required authorization by the Children's Medical Services Branch.

All other provider types must continue to bill using the "By Report" methodology currently in place using the *HCFA 1500* claim form.

Medi-Cal will continue to reimburse providers the lesser of the manufacturer's Average Selling Price plus 20 percent or the provider's usual and customary charge.

Provider manual pages regarding this policy will be updated in a future *Medi-Cal Update*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	cal child ser 1/2, 5/6, 11 thru 18, 21/22
	hcpcs ii 1/2 *
	hcpcs iii 1/2 *
	inject list 3/4 *
Remove:	modif app 1 thru 7
Insert:	modif app 1 thru 10 *
	oth hlth cpt 1/2 *
	ub sub 3/4, 5/6 *

* Pages updated due to ongoing provider manual revisions.